New York
47(x)(2)(b)

Attachment 4.19D
Part I

For the period April 1, 1997 through March 31, 1999, proportionate share payments in an annual aggregate amount of $631.1 million shall be made under the medical assistance program to non-state public operated residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For payments effective August 1, 1999, for the period April 1, 1999 through March 31, 2000, proportionate share payments in an annual aggregate amount of $914.5 million shall be made under the medical assistance program to non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau and the county of Westchester, but excluding public residential health care facilities operated by a town or city within a county.

The amount allocated to each eligible public residential health care facility for the period April 1, 1997 through March 31, 1998 shall be calculated as the result of $631.1 million multiplied by the ratio of their 1995 Medicaid days relative to the sum of 1995 Medicaid days for all eligible public residential health care facilities. The amount allocated to each eligible public residential health care facility for the period April 1, 1998 through March 31, 1999 shall be relative to the sum of 1996 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for the period April 1, 1999 through March 31, 2000 shall be calculated as the result of $914.5 million multiplied by the ratio of their 1997 Medicaid days relative to the sum of 1997 Medicaid days for all eligible public residential health care facilities. The payments are made contingent upon receipt of all approvals required by federal law or regulation.

Payments shall be made as a lump sum payment to each eligible residential health care facility.

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TN 99-32 1 Approval Date NOV 23 1999
Supersedes TN 97-25 Effective Date AUG 1 1999

prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facilities cost report submitted pursuant to this Subpart is less than the staffing pattern ~~required by~~ identified in ~~section 415.39 of this title~~ Appendix 3 of this State Plan.

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (d)(4)-(6) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, a facility's indirect costs shall be compared to the peer group established pursuant to clause (d)(2)(iii)(a) of this section.

(3) The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual cost in such cost report for personnel that would be reported in the functional cost centers identified in subdivision (f) of this section.

~~[(4) The provision of this subdivision will expire on December 31, 1994.]~~

TN 95-04 JUN 4 - 1999
Supersedes TN New Date JAN - 1 1995

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(w) Specialized programs for residents requiring behavioral interventions. Facilities which have been approved to operate discrete units specifically designed for the purpose of providing specialized programs for residents requiring behavioral interventions as established pursuant to section 415.39 of this Title shall have separate and distinct payment rates calculated pursuant to this section except as follows:

(1) In determining the facility specific direct adjusted payment price per day pursuant to paragraph (c)(4) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, the case mix index used to establish the statewide ceiling price per day for each patient classification group pursuant to subparagraph (c)(3)(iii) of this section for such residents shall be increased by an increment of 1.40. In determining the case mix adjustment pursuant to paragraph (c)(6) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.40.

(i) Specific interventions that the Department has approved which qualify for payment are a combination of medical and behavioral interventions such as counseling, recreation and exercise carried out in a therapeutic environment and provided on-site. Nursing resident criteria to be used in determining eligibility for payment include assessment of whether the resident is a danger to self or others and displays violent or aggressive behaviors which are typically exhibited as physical or verbal aggression such as clear threats of violence. The behavior may be unpredictable, recurrent for no apparent reason, and typically exhibited as assaultive, combative, disruptive or socially inappropriate behavior such as sexual molestation or fire setting.

(ii) The increment established in paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or

prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required below.

A current period audit of current period expenses will result in an incremental adjustment implemented on a prospective basis. An audit of prior period expenses will result in a retrospective adjustment in a lump sum payment. The staffing pattern required by the department is as follows:

(a) The unit shall be managed by a program coordinator;

(b) A physician shall be responsible for medical director and oversight of the program;

(c) A qualified specialist in psychiatry, a psychologist and a social worker shall be available on staff on a consulting basis;

(d) Other than the program coordinator, there shall be at least one registered professional nurse on each shift.

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (d)(4)-(6) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, a facility's indirect costs shall be compared to the peer group established pursuant to clause (d)(2)(iii)(a) of this section.

(3) The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual cost in such cost report for personnel required by section 415.39 of this Title that would be reported in the functional cost centers identified in subdivision (f) of this section.

(4) The provision of this subdivision will expire on December 31, 1994.

Description of the Specific Methodology Used in Determining the Adjustment

In order to determine the impact of the federal law on New York facilities, a cost estimate was made for each added code requirement. The total average additional cost was determined to be 45 cents per patient day.

Resident Assessments

Since New York State facilities were required prior to the new federal code to conduct accurate and comprehensive assessments, the additional cost pertains to completion of the MDS+[2] document and RN coordination and certification of completeness. No discipline other than RN is required, although facilities may choose to assign portions of the MDS+ to various disciplines as appropriate. Physician responsibilities remain the same as prior to the new code.

Comprehensive assessments include those performed on initial admission, annually, and upon significant change in resident status. It is estimated that there will be 1.48 comprehensive assessments per bed in 1991. This was based on an estimated significant change rate of 50% of the beds per year, and a 45% turnover rate per year. One twelfth of the annual assessments will be completed each month. Similarly, one twelfth of the assessments necessitated by the 45% turnover rate and the 50% significant change rate will also be completed each month. Half of the time, either of the latter two assessments will occur before the scheduled annual assessment of the resident in that bed, and the scheduled annual assessment will therefore not be necessary for that resident. The number of scheduled annual assessments not necessary under this methodology equals half of the new admit assessments and residents with a significant change, or (.5) ((.45) + (.5)) = .48. The total number of assessments per bed would be 1 + .48 = 1.48.

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[2]MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening

Based on a time study of the MDS[3], it was estimated that each comprehensive assessment would require one hour and forty five minutes, or forty five minutes longer than current practice. An average RN hourly salary rate of $24.00 as reported by industry representatives was used to make this calculation. The total cost was estimated as follows:

(# assessments/bed) (# beds) (incremental time/assessment)

(1.48) (105,000) (.75) ($24) = $2,797,200 for comprehensive assessments

Quarterly resident assessment reviews are estimated to be 2.2 per bed per year, at 30 minutes per assessment, with the remaining assumptions the same as for comprehensive assessments.

(2.2) (105,000) (.5) ($24) = $2,772,000 for quarterly assessments

TN 96-03 Approval Date JUN 26 1996
Supersedes TN 95-03 Effective Date OCT 1 - 1996

[3]MDS (Minimum Data Set)

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Comprehensive Care Plan

The incremental cost of comprehensive care plans for all residents was estimated by determining the added time of each participating discipline and multiplying by the average salary rate for that discipline. Physician participation in the care planning process has been a standard of practice in this State, and no additional time should be necessary under the new code. Based on an analysis of 1990 Patient Review Instrument (PRI) data, physical therapy (provided by a licensed physical therapist) was received by 21% of residents, and 9% received Occupational Therapy. Based on the new code requirements, it is estimated that twice this number, or 42% PT and 18% OT, will require additional care planning participation by these therapists. For those residents requiring PT/OT services, an additional half hour of PT/OT time will now be required. At an industry estimated hourly rate of $31.50 for physical therapists and $30.00 for occupational therapists, the added cost would be $15.74 for PT and $15.00 for OT for care plans for patients receiving therapy. The nursing home industry estimated that RN, social worker, dietician, and activities worker care planning time for 100% of care plans would each increase by .5 hour. The hourly rates provided by the industry for RNs were $24.00, for social workers $15.40, for dieticians $21.00, for activities workers $10.00. Based on 1.48 care plans per bed (using the number of comprehensive assessments per year), the calculation is as follows:

(# plans/bed) (# beds for all residents) (incremental time for EACH discipline x hourly rate x percent of care plans involving discipline) = statewide cost

(1.48)(105,000) ((.5 x $24 x 100%) + (.5 x $15.40 x 100%) + (.5 x $21.00 x 100%) + (.5 x $10.00 x 100%) + (.5 x $31.50 x 42%) + (.5 x $30.00 x 18%)) = $6,917,631

Quarterly Plan Reviews

Only an RN is involved in the incremental activities required by OBRA. The industry's estimate of 2.2 quarterly care plans per year at an incremental cost of $6.00 per review was used:

(# care plans/bed) (# beds) (incremental cost/plan) = statewide cost

(2.2) (105,000) ($6.00) = $1,386,000

Training on MDS+[4] Assessment

An estimate of $370,020 was used, based on the industry's estimate which was found acceptable:

Cost of training for up to 80 beds	$229,950
80 bed increments	$140,070
	$370,020

[4]MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)

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Quality Assurance

The meeting and preparation time for quarterly Quality Assurance meetings, including committee members of a physician, director of nursing, administrator or designee and three other staff was estimated by the industry. This was offset by the elimination of separate pharmacy reviews and infection control meetings, as well as the existing utilization review assessment and U/R committee meetings. Three added staff involved in meetings are assumed to be the physical therapist, social services director, and a representative from medical records. The net added expense estimated by the industry was $600,264.

Recertification of Nurse Aides

The number of aides who must be recertified by 1/92 is 17,381. The cost of recertification is $25.00 per aide. The total recertification cost is $434,525.

Psychotropic Drug Reviews

The code requires that all residents receiving psychotropic medications be reviewed with the intent of minimizing the usage of such drugs. These reviews are assumed to involve the physician and take about .5 hours per resident. It is estimated that 20% of residents will need such review at a physician cost of $150 per hour.

105,000 x 20% x .5 x $150 = $1,575,000

Surety Bonds

The industry has estimated that $189,000 of added cost will be incurred for this requirement and was found acceptable.

SUMMARY OF INCREMENTAL CODE COSTS TO BE REIMBURSED

Total incremental federal code cost to be recognized in facility 1991 rates is $17,041,640.

Comprehensive Resident Assessment	$ 2,797,200
Quarterly Resident Assessment	$ 2,772,000
Comprehensive Care Plan	$ 6,917,631
Quarterly Care Plan Review	$ 1,386,000
Training of MDS+[5]Assessment	$ 370,020
Quality Assurance	$ 600,264
Nurse Aide	$ 434,525
Psychotropic Drug Review	$ 1,575,000
Surety Bonds	$ 189,000
Total Incremental Cost	$17,041,640

TN 96-03 Approval Date JUN 26 1996
Supersedes TN 95-03 Effective Date OCT 1 - 1996

[5]MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)